Exhibit A

CLAIM FOR DAMAGE, INJURY, OR DEATH

INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.

FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:
REGIONAL COUNSEL (662/02)
U.S. DEPT. OF VETERANS AFFAIRS
VA MEDICAL CENTER, BLDG. 210
4150 CLEMENT STREET
SAN FRANCISCO, CA 94121

2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, street, city, State and Zip Code)
Dave Burkhart Sally
483 Hartnham Way
Camphell, Calif 95008

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☐ MILITARY ☒ CIVILIAN	11-14-31	Married	10-26-2003	Am

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurence and the cause thereof) (Use additional pages if necessary.)

Vetran death resulted in by misdiagnosed medical treatment - Lack of. Given drug Haldol with Heart problem placed in Hospice at Livermore. DR. Kuo dropped his insulin reading's to twice a week, I checked them 4 times day at home, He was placed in hospice, and had no Medical treatment. Died of heart decease sit. when he was on full co
in a Hospital.

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, street, city, State, and Zip Code)

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)

10. PERSONAL INJURY/WRONGFUL DEATH

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

Vetran death resulted by misdiagnosed medical treatment and lack of.

11. WITNESSES

NAME	ADDRESS (Number, street, city, State, and Zip Code)

12. (See instructions on reverse) AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights.)
		Misdiagnosed Lack of treatment	2.5 Million

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE ACCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.)	13b. Phone number of signatory	14. DATE OF CLAIM
Sally Burkhart	408-371-0646	10-11-05

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM
The claimant shall forfeit and pay to the United States the sum of $2,000. plus double the amount of damages sustained by the United States. (See 31 U.S.C. 3729.)

CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
Fine of not more than $10,000 or imprisonment for not more than 5 years or both. (See 18 U.S.C. 287, 1001.)

95-108
Previous editions not usable.

NSN 7540-00-634-4046

STANDARD FORM 95 (Rev. 7-85)
PRESCRIBED BY DEPT. OF JUSTICE
28 CFR 14.2

PRIVACY ACT NOTICE

This Notice is provided in accordance with the Privacy Act, 5 U.S.C. 552a(e)(3), and concerns the information requested in the letter to which this Notice is attached.

A. *Authority:* The requested information is solicited pursuant to one or more of the following: 5 U.S.C. 301, 28 U.S.C. 501 et seq., 28 U.S.C. 2671 et seq., 28 C.F.R. Part 14.

B. *Principal Purpose:* The information requested is to be used in evaluating claims.

C. *Routine Use:* See the Notices of Systems of Records for the agency to whom you are submitting this form for this information.

D. *Effect of Failure to Respond:* Disclosure is voluntary. However, failure to supply the requested information or to execute the form may render your claim "invalid".

INSTRUCTIONS

Complete all items - Insert the word NONE where applicable

A CLAIM SHALL BE DEEMED TO HAVE BEEN PRESENTED WHEN A FEDERAL AGENCY RECEIVES FROM A CLAIMANT, HIS DULY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE AN EXECUTED STANDARD FORM 95 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANIED BY A CLAIM FOR MONEY DAMAGES IN A SUM CERTAIN FOR INJURY TO OR LOSS OF PROPERTY, PERSONAL INJURY, OR DEATH ALLEGED TO HAVE OCCURRED BY REASON OF THE INCIDENT. THE CLAIM MUST BE PRESENTED TO THE APPROPRIATE FEDERAL AGENCY WITHIN TWO YEARS AFTER THE CLAIM ACCRUES.

Any instructions or information necessary in the preparation of your claim will be furnished, upon request, by the office indicated in item #4 on the reverse side. Complete regulations pertaining to claims asserted under the Federal Tort Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplemental regulations also. If more than one agency is involved, please state each agency.

The claim may be filed by a duly authorized agent or other legal representative, provided evidence satisfactory to the Government is submitted with said claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

If claimant intends to file claim for both personal injury and property damage, claim for both must be shown in item 12 of this form.

The amount claimed should be substantiated by competent evidence as follows:

(a) In support of the claim for personal injury or death, the claimant should submit a written report by the attending physician, showing the nature and extent of injury, the nature and extent of treatment, the degree of permanent disability, if any, the prognosis, and the period of hospitalization, or incapacitation, attaching itemized bills for medical, hospital, or burial expenses actually incurred.

(b) In support of claims for damage to property which has been or can be economically repaired, the claimant should submit at least two itemized signed statements or estimates by reliable, disinterested concerns, or, if payment has been made, the itemized signed receipts evidencing payment.

(c) In support of claims for damage to property which is not economically repairable, or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familiar with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.

(d) Failure to completely execute this form or to supply the requested material within two years from the date the allegations accrued may render your claim "invalid". A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

Failure to specify a sum certain will result in invalid presentation of your claim and may result in forfeiture of your rights.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden,

to Director, Torts Branch
Civil Division
U.S. Department of Justice
Washington, DC 20530

and to the
Office of Management and Budget
Paperwork Reduction Project (1105-0008)
Washington, DC 20503

INSURANCE COVERAGE

In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of his vehicle or property.

15. Do you carry accident insurance? ☐ Yes, if yes, give name and address of insurance company *(Number, street, city, State, and Zip Code)* and policy number. ☐ No

16. Have you filed claim on your insurance carrier in this instance, and if so, is it full coverage or deductible?

17. If deductible, state amount

18. If claim has been filed with your carrier, what action has your insurer taken or proposes to take with reference to your claim? *(It is necessary that you ascertain these facts)*

19. Do you carry public liability and property damage insurance? ☐ Yes, if yes, give name and address of insurance carrier *(Number, street, city, State, and Zip Code)* ☐ No

October 16, 05

PLT'S COUNSEL

David was admitted to Palo Alto Hospital 9-30-02. Then sent to Menlo Park VA. where he was given Lisinopril. He was allergic to this, but they failed to take it out of the medical records on the computer in Menlo Park.

This put him into Cardiac Arrest, and they sent him back to Palo Alto in an ambulance. There they pumped it out of him.

They told us he couldn't stay in Palo Alto, we had to find a place for him. They used a lift to move him.

We found a Nursing home Terrena gardens, by our house.

Palo Alto VA sent him on a journey (he was to walk to sit in this wheel chair) and was admitted. He was there just a couple days when they sent him in an ambulance to Good Samaritan Hospital. They admitted him with Cardiac Arrest.

(2)

When he came home from the nursing home (Stay Sept to June) I had a caregiver to help me in our home.

He went up to Palo Alto he was there about week. Came back home.

In September he went back to the hospital in Palo Alto (He should have been admitted, but was sent home at 11:30 at nite on a gurney.

Three day's later the VA sent a Van, he went back up to Palo Alto and finally admitted him.

Then Palo Alto told me he couldn't stay there.

I had a Lift on order from the VA and asked if he could stay until I got the lift. They said no!

Then they gave him Haldol to get him to Livermore. Because he didn't want to go.

(3)

The nite before he went to Livermore I called and spoke to him. He sounded like he was much better and stronger. I spoke to the nite nurse, he said he was a perfect gentleman and doing better.

When I went up to visit him in Livermore he was really sick. He was white, cold, clamy, gray throwing up, couldn't eat. He looked awful, Sweating & white, not at all like the way he sounded in Palo Alto on the phone.

I called the rotating Doctor in Livermore, and asked him if Dr. Kuo left him any notes to check him on weekends. He told me no no message. Said he would have / But she left no note

They put him in the Hospice area and dropped his insulin checks to 2 times a week, at home I checked it 4 times a day.

We were never told he was in the Hospice area, He was on Face ca

(4)

The nurses in Livermore told me they just try and ignore the patients confortable in the Hospice area. They don't really treat them.

I was never told they placed him in Hospice area.

He was a diabetic, they should have checked on him.

He was throwing up and didn't eat, lost alot of weight.

I asked the VA do weigh him, when they did the autopsy.

She told me they would.

They never did! They told me they didn't have a scale in the VA Hospital in Pal Alto.

I believe if he had been at Good Samaritan Hospital he would be alive today.

The best hospitals take care of the sickest patients.

The VA system dumps patients.

PATIENT NAME: BURKHART,DAVE
UNIT NO: M000551642

EXAMS: **CPT:**
000552707 GD CHEST 1V PORT 71010

EXAM: SINGLE PORTABLE VIEW OF THE CHEST, 10/3/2002, 1057 HOURS.
X552707

FINDINGS: The cardiac silhouette is upper limits of normal in size. The interstitial markings are prominent with indistinct pulmonary vasculature. The left hemidiaphragm is obscured, as are both costophrenic angles. The overall appearance is suggestive of congestive heart failure. Clinical correlation is needed. Median sternotomy wires are in place. The bones and underlying soft tissues are unremarkable.

IMPRESSION: CHF, with small bilateral pleural effusions.

DICTATED: 10/3/2002,1640.

Reported by: Denise K. Wise, M.D.

This is after they gave him Lasix at VA and wouldn't keep him in hospital - Good Sam hospital admitted him, a few days later.

CC: Bertha Chen MD

DICTATED DATE/TIME: 10/03/2002 (1640)
TECHNOLOGIST: Darnall,Sheri L
TRANSCRIBED DATE/TIME: 10/03/2002 (2216)
TRANSCRIPTIONIST: MARCOSN
PRINTED DATE/TIME: 10/04/2002 (1114) BATCH NO: N/A

 Draft Report Printed From PCI

GOOD SAMARITAN HOSPITAL
2425 Samaritan Drive
San Jose, CA 95124

PHONE #: (408)559-2141
FAX #: (408)559-2679

NAME: BURKHART,DAVE
PHYS: ERIMI - Ericksen,Michael MD
DOB: 11/14/1931 AGE: 70 SEX: M
ACCT NO: M00066714247 LOC: M.327 1
EXAM DATE: 10/03/2002 STATUS: ADM IN
RADIOLOGY NO:

CLAIM FOR DAMAGE, INJURY, OR DEATH

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4150 CLEMENT STREET
SAN FRANCISCO, CA 94121

2. Name, Address of claimant and claimant's personal representative, if any. *(See instructions on reverse.) (Number, street, city, State and Zip Code)*
Dave Burkhart
483 Notting Ham Way
Campbell, Ca 95008

3. TYPE OF EMPLOYMENT: ☐ MILITARY ☑ CIVILIAN
4. DATE OF BIRTH: 11-14-1931
5. MARITAL STATUS: Married
6. DATE AND DAY OF ACCIDENT: 10-26-2003
7. TIME *(A.M. or P.M.)*:

8. Basis of Claim *(State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof) (Use additional pages if necessary.)*

Veteran death resulted by mis diagnosed medical treatment. lack of given Haldel with Heart problem Dr Kuo, Livermore, Hospice Area, when he was on full code

PROPERTY DAMAGE

9. NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT *(Number, street, city, State, and Zip Code)*

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. *(See instructions on reverse side.)*

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10. STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

Given Lisinopril in Menlo park put in Cardiac Arrest. Said he couldn't stay. Admitted him to Public Nursing Home and they sent him to Good Sam Hospital in San Jose they admitted him with Cardiac Arrest. In Sept 2003 was admitted to Palo Alto, said he couldn't stay to Livermore was put in Hospice area gave him Haldel Sent Him when he was on full code dropped his insulin to two times a week, at home I checked it 4 times a day. Lost a lot of weight Asked them to weigh him with Autopsy. they did and said there wasn't scale in the VA Hospital.

11. WITNESSES

NAME	ADDRESS (Number, street, city, State, and Zip Code)

12. *(See instructions on reverse)* AMOUNT OF CLAIM *(in dollars)*

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL *(Failure to specify may cause forfeiture of your rights.)*
		Mis diagnosed lack of treatment	2 Million

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE ACCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM.

13a. SIGNATURE OF CLAIMANT *(See instructions on reverse side.)*	13b. Phone number of signatory	14. DATE OF CLAIM
Sally Burkhart	408 3710646	10-11-05

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CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS

Fine of not more than $10,000 or imprisonment for not more than 5 years or both. *(See 18 U.S.C. 287, 1001.)*

RECEIVED OCT 21 2005 VARO

95-109
Previous editions not usable.
Designed using Perform Pro, WHS/DIOR, Jun 98

NSN 7540-00-634-4046

STANDARD FORM 95 (Rev. 7-85) (EG)
PRESCRIBED BY DEPT. OF JUSTICE
28 CFR 14.2

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to Director, Torts Branch
Civil Division
U.S. Department of Justice
Washington, DC 20530

and to the
Office of Management and Budget
Paperwork Reduction Project (1105-0008)
Washington, DC 20503

INSURANCE COVERAGE

In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of his vehicle or property.

15. Do you carry accident insurance? ☐ Yes, If yes, give name and address of insurance company *(Number, street, city, State, and Zip Code)* and policy number. ☐ No

16. Have you filed claim on your insurance carrier in this instance, and if so, is it full coverage or deductible?

17. If deductible, state amount

18. If claim has been filed with your carrier, what action has your insurer taken or proposes to take with reference to your claim? *(It is necessary that you ascertain these facts)*

19. Do you carry public liability and property damage insurance? ☐ Yes, If yes, give name and address of insurance company *(Number, street, city, State, and Zip Code)* ☐ No

SF 95 (Rev. 7-85) BACK

Exhibit B

CERTIFICATION OF VITAL RECORD

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

PUBLIC HEALTH DEPARTMENT

CERTIFICATE OF DEATH

STATE OF CALIFORNIA

Local Registration Number: 3200301007298

Decedent's Personal Data

- 1. Name of Decedent — First: DAVID
- 2. Middle: -
- 3. Last: BURKHART
- 4. Date of Birth: 11/14/1931
- 5. Age Yrs.: 71
- 6. Sex: M
- 7. Date of Death: 10/26/2003
- 8. Hour: 0648
- 9. Birth State/Foreign Country: OK
- 10. Social Security Number: [redacted]
- 11. Ever in U.S. Armed Forces: [X] Yes [ ] No [ ] Unk
- 12. Marital Status: MARRIED
- Decedent's Race: CAUCASIAN
- [Hispanic/Latino/Spanish]: [X] No
- Education: SOME COLLEGE
- 17. Usual Occupation: SELF EMPLOYED
- Kind of Business or Industry: FOOD
- Years in Occupation: 40

Usual Residence

- 20. Decedent's Residence: 1822 LENCAR WAY
- 21. City: SAN JOSE
- 22. County/Province: SANTA CLARA
- 23. Zip Code: 95124
- 24. Years in County: 5
- 25. State/Foreign Country: CA

Informant

- 26. Informant's Name, Relationship: LISA HARAN - DAUGHTER
- 27. Informant's Mailing Address: 1564 WILLOWGATE DRIVE SAN JOSE, CA 95118

Spouse and Parent Information

- 28. Name of Surviving Spouse — First: SALLY
- 29. Middle: ANN
- 30. Last (Maiden Name): THEDE
- 31. Name of Father — First: JOSEPH
- 32. Middle: L.
- 33. Last: BURKHART
- 34. Birth State: CANADA
- 35. Name of Mother — First: LONA
- 36. Middle: MARIE
- 37. Last (Maiden): ROBINSON
- 38. Birth State: OK

Funeral Director / Local Registrar

- 39. Disposition Date: 11/06/2003
- 40. Place of Final Disposition: SAN JOAQUIN VALLEY NATIONAL CEMETERY 32053 W. MC CABE RD GUSTINE, CA
- 41. Type of Disposition: BURIAL
- 42. Signature of Embalmer: Michael Skolnick
- 43. License Number: 7381
- 44. Name of Funeral Establishment: OAK HILL FUNERAL HOME
- 45. License Number: FD 991
- 46. Signature of Local Registrar: [signature] m.d.
- 47. Date: 11/05/2003

Place of Death

- 101. Place of Death: VA HEALTH CARE SYSTEM
- 102. If Hospital: [X] IP [ ] ER/OP [ ] DOA
- 104. County: ALAMEDA
- 105. Facility Address: 4951 ARROYO ROAD
- 106. City: LIVERMORE

Cause of Death

- 107. Cause of Death — Immediate Cause (A): CORONARY ARTERY DISEASE — Time Interval: YEARS
- (B): MULTI-INFARCT DEMENTIA — Time Interval: YEARS
- 108. Death Reported to Coroner: [ ] Yes [X] No
- 109. Biopsy Performed: [ ] Yes [X] No
- 110. Autopsy Performed: [ ] Yes [X] No
- 111. Used in Determining Cause: [ ] Yes [ ] No
- 112. Other Significant Conditions Contributing to Death but not Resulting in the Underlying Cause Given in 107: CONGESTIVE HEART FAILURE, DIABETES MILLITUS, HYPERTENSION, OSTEOMYELITIS
- 113. Was Operation Performed for Any Condition in Item 107 or 112: NO

Physician's Certification

- 114. I certify that to the best of my knowledge death occurred at the hour, date, and place stated from the causes stated. Decedent Attended Since: 09/29/2003 — Decedent Last Seen Alive: 10/26/2003
- 115. Signature and Title of Certifier: [signature]
- 116. License Number: A66866
- 117. Date: 10/27/2003
- 118. Type Attending Physician's Name, Mailing Address, Zip Code: MONIQUE KUO MD. 4951 ARROYO ROAD, LIVERMORE, CA. 94550

Coroner's Use Only

- 119. Manner of Death: [ ] Natural [ ] Accident [ ] Homicide [ ] Suicide [ ] Pending Investigation [ ] Could not be determined
- 120. Injured at Work: [ ] Yes [ ] No [ ] Unk
- 121. Injury Date:
- 122. Hour:
- 123. Place of Injury:
- 124. Describe How Injury Occurred:
- 125. Location of Injury:
- 126. Signature of Coroner / Deputy Coroner:
- 127. Date:
- 128. Type Name, Title of Coroner / Deputy Coroner:

State Registrar: A | B | C | D | E — Fax Auth. #: 27002

000378419

CERTIFIED COPY OF VITAL RECORDS [signature] m.d.

STATE OF CALIFORNIA } ss
COUNTY OF ALAMEDA }

This is a true and exact reproduction of the document officially registered and filed with the Alameda County Health Care Services Agency.

DATE ISSUED: 11/12/2003

[signature]
HEALTH OFFICER AND LOCAL REGISTRAR
ALAMEDA COUNTY

THE GREAT SEAL OF THE STATE OF CALIFORNIA — EUREKA

This copy not valid unless prepared on engraved border displaying date and signature of Registrar

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11 (REV 1/03)

LOCAL REGISTRATION NUMBER

STATE FILE NUMBER

DECEDENT'S PERSONAL DATA

1. NAME OF DECEDENT — FIRST (Given): DAVE
2. MIDDLE:
3. LAST (Family): BURKHART
4. DATE OF BIRTH mm/dd/ccyy:
5. AGE Yrs. (If UNDER ONE YEAR: Months, Days; If UNDER 24 HOURS: Hours, Minutes)
6. SEX:
AKA. ALSO KNOWN AS — Include full AKA (FIRST, MIDDLE, LAST):
7. DATE OF DEATH mm/dd/ccyy: 10/25/2003
8. HOUR (24 Hours): 0648
9. BIRTH STATE/FOREIGN COUNTRY:
10. SOCIAL SECURITY NUMBER: [redacted]
11. EVER IN U.S. ARMED FORCES? YES NO UNK
12. MARITAL STATUS (at time of death):
13. EDUCATION — Highest Level/Degree (see worksheet on back):
14/15. WAS DECEDENT SPANISH/HISPANIC/LATINO? (If yes, see worksheet on back.) YES NO
16. DECEDENT'S RACE — Up to 5 races may be listed (see worksheet on back):
17. USUAL OCCUPATION — Type of work for most of life. DO NOT USE RETIRED:
18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.):
19. YEARS IN OCCUPATION:

RESIDENCE

20. DECEDENT'S RESIDENCE (Street and number or location):
21. CITY:
22. COUNTY/PROVINCE:
23. ZIP CODE:
24. YEARS IN COUNTY:
25. STATE/FOREIGN COUNTRY:

INFORMANT

26. INFORMANT'S NAME, RELATIONSHIP:
27. INFORMANT'S MAILING ADDRESS (Street and number or rural route number, city or town, state, ZIP):

PERSONAL INFORMATION

28. NAME OF SURVIVING SPOUSE — FIRST:
29. MIDDLE:
30. LAST (Maiden Name):
31. NAME OF FATHER — FIRST:
32. MIDDLE:
33. LAST:
34. BIRTH STATE:
35. NAME OF MOTHER — FIRST:
36. MIDDLE:
37. LAST (Maiden):
38. BIRTH STATE:

LOCAL REGISTRAR

39. DISPOSITION DATE mm/dd/ccyy:
40. PLACE OF FINAL DISPOSITION:
41. TYPE OF DISPOSITION(S):
42. SIGNATURE OF EMBALMER:
43. LICENSE NUMBER:
44. NAME OF FUNERAL ESTABLISHMENT:
45. LICENSE NUMBER:
46. SIGNATURE OF LOCAL REGISTRAR:
47. DATE mm/dd/ccyy:

DEATH

100. PLACE OF DEATH: VA HEALTH CARE SYSTEM
101. IF HOSPITAL, SPECIFY ONE: [X] IP [ ] ER/OP [ ] DOA
102. IF OTHER THAN HOSPITAL, SPECIFY ONE: [ ] Hospice [ ] Nursing Home/LTC [ ] Decedent's Home [ ] Other
103. CITY: LIVERMORE
104. COUNTY: ALAMEDA
105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number or location): 4951 ARROYO ROAD

CAUSE OF DEATH

107. CAUSE OF DEATH — Enter the chain of events — diseases, injuries, or complications — that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

Time Interval Between Onset and Death:

IMMEDIATE CAUSE (Final disease or condition resulting in death): (A) CORONARY ARTERY DISEASE (AT) YEARS
Sequentially, list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST:
(B) MULTI-INFARCT DEMENTIA (BT) YEARS
(C) (CT)
(D) (DT)

106. DEATH REPORTED TO CORONER? [ ] YES [X] NO — REFERRAL NUMBER
108. BIOPSY PERFORMED? [ ] YES [X] NO
109. AUTOPSY PERFORMED? [ ] YES [X] NO
111. USED IN DETERMINING CAUSE? [ ] YES [ ] NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107: CONGESTIVE HEART FAILURE, DIABETES MILLITUS, HYPERTENSION, OSTEOMYELITIS

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)
113A. IF FEMALE, PREGNANT IN LAST YEAR? [ ] YES [ ] NO [ ] UNK

PHYSICIAN'S CERTIFICATION

114. CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.
Decedent Attended Since: (A) mm/dd/ccyy: 09/29/2003
Decedent Last Seen Alive: (B) mm/dd/ccyy: 10/26/2003
115. SIGNATURE AND TITLE OF CERTIFIER:
116. LICENSE NUMBER: A66866
117. DATE mm/dd/ccyy: 10/27/2003
118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE: MONIQUE KUO MD. 4951 ARROYO ROAD, LIVERMORE, CA. 94550

CORONER'S USE ONLY

119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.
MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Homicide [ ] Suicide [ ] Pending Investigation [ ] Could not be determined
120. INJURED AT WORK? [ ] YES [ ] NO [ ] UNK
121. INJURY DATE mm/dd/ccyy:
122. HOUR (24 Hours):
123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.):
124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury):
125. LOCATION OF INJURY (Street and number, or location, and city, and ZIP):
126. SIGNATURE OF CORONER / DEPUTY CORONER:
127. DATE mm/dd/ccyy:
128. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER:

STATE REGISTRAR: A | B | C | D | E
FAX AUTH. #:
CENSUS TRACT:

MEDICAL RECORD | DISPOSITION BODY

RECEIPT OF BODY AT MORGUE

The body of ..... was
(Name)

received at ..... A. M. P. M. on .....
(Date)

.....
(Signature)

CERTIFICATE OF REMOVAL

The body of DAVE BURKHART was removed
(Name)

by Callaghans
(Name and address of undertaker)

at 11:15 A. M. P. M. on 10-26-03
(Date)

.....
(Signature of person releasing body to undertaker)

.....
(Signature of representative of undertaker)

The following statement shall be completed only when specifically ordered.

PHYSICIAN'S STATEMENT REGARDING CONDITION OF REMAINS AS RELEASED (Describe post-mortem, surface discolorations, abrasions, lesions, incisions, whether remains were embalmed, etc.)

.....
(Signature of physician)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—Last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

WARD NO.

DEPARTMENT OF VETERANS AFFAIRS
MEDICAL CENTER
LIVERMORE, CALIFORNIA

DISPOSITION OF BODY
Standard Form 523A (Rev. 10-75)
Prescribed by General Services Administration and Interagency Comm on Medical Records
FIRMR (41 CFR 201-45.505 — 523-207

BURKHART, DAVE
[redacted] 11/14/31

[redacted]

[redacted]

Department of Veterans Affairs

NOTICE TO PERSON DESIGNATED BY VETERAN REGARDING PERSONAL EFFECTS

PART I–NOTICE TO DESIGNEE AND/OR RELATIVES OF VETERAN

NAME OF DECEASED VETERAN	CLAIM NO.	DATE OF NOTICE
Burkhart, Dave	~~SSN~~ [redacted]	10/26/03
PLACE OF DEATH	DATE OF DEATH	CASH LEFT BY VETERAN
VA Health Care System	10/26/03	$ -0-
PERSON NAMED AS DESIGNEE	PERSON NAMED AS ALTERNATE DESIGNEE	
David Burkhart (Son)		

You are hereby notified that the deceased veteran named above left cash among his/her effects and property. (Cash is in the amount shown above; effects and property as listed on the enclosed inventory or on the reverse of this form). The veteran has named the designee shown above to whom possession of such property may be delivered. If not delivered to the designee within 90 days or to the alternate designee within 120 days from the date of this notice the property will be sold at the time and place stated on the reverse side hereof, unless prior to that date it is claimed by and delivered to one or more of the persons entitled to possession. Cost of shipment not exceeding $25 will be paid by the Government. Unless claimed by the executor or administrator of deceased, possession will be delivered (if claimed) to the spouse, child, grandchild, mother, father, grandmother, grandfather, brother, or sister (in the order named), if such are named among those whom the deceased stated were his relatives (named below). If claimant is a minor or is incompetent delivery will be to his/her guardian. Waiver by each entitled to priority is necessary to deliver to one subsequently entitled. Notwithstanding such delivery the beneficial interest in such property shall be subject to distribution in accordance with the deceased's will, if any; or if intestate in accordance with the law of decedent's domicile. Delivery does not vest title in the person to whom delivery is made. If such property is sold, the net proceeds will be deposited in the United States Treasury for credit to the General Post Fund and may be reclaimed within 5 years after the date of this notice by the person or persons to whom title thereto vested upon death of the owner. You may make claim to person, or by writing the undersigned proper shipping instructions. The following statement should be signed and this notice returned to this facility.

VA FACILITY (Name and address)	SIGNATURE OF DIRECTOR OR DESIGNEE
4951 Arroyo road Livermore CA 94550	Ken Owens, Acting Chief Business Office

PART II–CLAIM FOR EFFECTS AND CASH

I hereby make claim for the effects and cash left by the above-named veteran. I understand that possession only will be transferred to me; that such transfer does not in itself affect title thereto and that I will be accountable to the person or persons legally entitled to such property.

SIGNATURE OF CLAIMANT	DATE	ADDRESS OF CLAIMANT
D. T. B[redacted]	10/26/2003	[redacted]

PART III–CERTIFICATION BY VA DIRECTOR OR DESIGNEE

I certify that all requirements of Title 38, U.S.C. and regulations of the Department of Veterans Affairs have been complied with in respect to the property listed herein. Also this notice was sent by mail to the following on the dates stated:

NAME (List Person(s) designated on VA FORM 10-10 or 10-10d to receive possession of Personal Property)	ADDRESS	DATE MAILED
~~Bag~~ Cap Clothes Mirror Glasses Dentures Soap Shampoo Brush	US03047	

PROPERTY WAS	DATE PROPERTY DISPOSED OF	DATE OF MEMO AUTHORIZING DISPOSITION OF FUNDS	SIGNATURE OF DIRECTOR OR DESIGNEE
☐ DELIVERED ☐ SHIPPED ☐ SOLD AMOUNT REALIZED $			Ken Owens Acting Chief Business Office

VA FORM 10-1171 JUL 1993

EXISTING STOCK OF VA FORM 10-1171 SEP 1972 WILL BE USED

[redacted]

Veterans Administration

APPLICATION FOR UNITED STATES FLAG FOR BURIAL PURPOSES

Postmaster or other issuing official: Submit this form to the nearest VA Regional Office. Be sure to complete the stub at the bottom.

LAST NAME - FIRST NAME - MIDDLE NAME OF DECEASED (Print or type)
Burkhart, David

BRANCH OF SERVICE (Check)
☒ ARMY ☐ NAVY ☐ AIR FORCE ☐ MARINE CORPS ☐ COAST GUARD ☐ OTHER (Specify)

VETERAN'S SERVICE (Check)
☐ SPANISH AMERICAN ☐ WW I ☐ WW II ☒ KOREAN CONFLICT ☐ AFTER 1-31-55 ☐ VIETNAM ERA ☐ OTHER (Specify)

CONDITION UNDER WHICH VETERAN WAS RELEASED FROM SERVICE (Check)
☒ 1. VETERAN OF A WAR, MEXICAN BORDER SERVICE, OR OF SERVICE AFTER 1-31-55, DISCHARGED OR RELEASED FROM ACTIVE DUTY UNDER CONDITIONS OTHER THAN DISHONORABLE.
☐ 2. DISCHARGED FROM, OR RELEASED FROM ACTIVE DUTY IN U.S. ARMED FORCES UNDER CONDITIONS OTHER THAN DISHONORABLE, AFTER SERVING AT LEAST ONE ENLISTMENT, OR DISCHARGED FOR DISABILITY INCURRED IN LINE OF DUTY.
☐ 3. BY DEATH IN ACTIVE SERVICE AFTER MAY 27, 1941, AND FLAG NOT FURNISHED BY THE SERVICE DEPARTMENT.
☐ 4. SEPARATED FROM PHILIPPINE MILITARY FORCES, UNDER CONDITIONS OTHER THAN DISHONORABLE, AFTER SERVING UNITED STATES IN SUCH FORCES UNDER PRESIDENT'S ORDER OF JULY 26, 1941, AND DIED ON OR AFTER APRIL 25, 1951.

NAME OF PERSON ENTITLED TO RECEIVE FLAG
David Burkhart

RELATIONSHIP TO DECEASED
Son

ADDRESS OF PERSON ENTITLED TO RECEIVE FLAG
[redacted]

PERSONAL DATA OF DECEASED (To be completed if possible)

VA FILE NUMBER	SOCIAL SECURITY NUMBER	SERVICE SERIAL NUMBER
	[redacted]	

DATE OF ENLISTMENT	DATE OF DISCHARGE	DATE OF BIRTH	DATE OF DEATH
		11/14/31	10/26/2003

DATE OF BURIAL	PLACE OF BURIAL (Name of Cemetery, city, and State)

REMARKS

I CERTIFY that, to the best of my knowledge and belief, the statements made above are correct and true, the deceased is eligible, in accordance with attached Instructions, for issue of a United States flag for burial purposes, and such flag has not previously been applied for or furnished.

SIGNATURE OF APPLICANT (Sign in INK)	ADDRESS	RELATIONSHIP TO DECEASED	DATE
[signature]	[redacted]	Son	10/26/2013

PENALTY—The law provides that whoever makes any statement of a material fact knowing it to be false shall be punished by a fine or by imprisonment or both.

ACKNOWLEDGMENT OF RECEIPT OF FLAG

I CERTIFY that the flag requested by the applicant will be used to drape the casket of the deceased in whose honor it is issued by the Veterans Administration; and that paragraph 7 of the attached Instructions will be complied with.

SIGNATURE OF PERSON RECEIVING FLAG (Sign in INK)	DATE FLAG RECEIVED

NAME AND ADDRESS OF POST OFFICE OR OTHER FLAG ISSUE POINT	FOR VA USE	
	DATE NOTIFICATION FORWARDED TO SUPPLY	INITIALS OF RESPONSIBLE VA EMPLOYEE

VA FORM DEC 1985 90-2008

BEST AVAILABLE

This stub is to be completed by the POSTMASTER or other issuing official. Upon receipt the VA Regional Office will detach and forward it to the appropriate Supply Officer.

NOTIFICATION OF ISSUANCE OF FLAG

DATE FLAG ISSUED	SIGNATURE OF POSTMASTER OR OTHER ISSUING OFFICIAL (Sign in INK)	ADDRESS
		US03048
FOR VA USE ▶	DATE OF REPLACEMENT	

VA FORM DEC 1985 90-2008

EXISTING STOCKS OF VA FORM 60-2008, 00-2008, AND 90-2008, FEB 1979, WILL BE USED.

663756